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EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

	, request limited emergency care as herein described.
(print patient's name)	
understand DNR means that if my heart stops bear reathing or heart functioning will be instituted.	ating or if I stop breathing, no medical procedure to restart
understand this decision will not prevent me from mergency medical care personnel and/or medical	n obtaining other emergency medical care by prehospital care directed by a physician prior to my death.
understand I may revoke this directive at any tim	e by destroying this form and removing any "DNR" medallions
give permission for this information to be given t ther health personnel as necessary to implement t	to the prehospital emergency care personnel, doctors, nurses or this directive.
hereby agree to the "Do Not Resuscitate" (DNR)	order.
tient/Legally Recognized Health Care Decisionmaker Signature	Date
egally Recognized Health Care Decisionmaker's Relationship to I	
s signing this form, the legally recognized health care decisionma e known desires of, and with the best interest of, the individual wi	aker acknowledges that this request to forego resuscitative measures is consistent with to is the subject of the form.
07 d d d d d d d d d d d d d d d d d d d	1
irective is the expressed wish of the patient/legal	care decisionmaker is making an informed decision and that the fly recognized health care decisionmaker. A copy of this form
the patient's permanent medical record.	
the event of cardiac or rechiratory arrest no chu	est compressions, assisted ventilations, intubation, defibrillation
r cardiotonic medications are to be initiated.	est compressions, assisted ventuations, intubation, denormation
sysician Signature	Date
int Name	Telephone
19-10-10-10-10-10-10-10-10-10-10-10-10-10-	*************************************
THIS FORM WILL NOT BE ACCEPTED IF IT I	HAS BEEN AMENDED OR ALTERED IN ANY WAY

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